



King County

May 20, 2011

Transforming Health for King County's Low-Income and Underserved Residents

Health care reform is rapidly taking shape in our state, with Governor Gregoire and her team developing increasingly specific proposals to redesign the health system in preparation for full implementation by 2014. These changes stand to have significant impacts on the residents of King County, particularly those with low incomes, and the health and human service systems that support them. Now is the time to come together to help shape those proposals, think through implications, and assure that those who will be most affected by the changes ahead are involved in the dialogue.

King County intends to convene stakeholders to develop options for the design of an integrated service delivery model that improves the health of King County's safety net population while controlling costs. Along with the health care and behavioral health systems, we will engage other key community-based service systems that play significant roles in the health of our most vulnerable individuals and families.

We are seeking your input on a clear deliverable and an effective process that will be well-coordinated with related activities. This paper presents the following questions and our thinking to date for your consideration:

1. *What is King County's vision for the health of communities and individuals?*
2. *How has our community worked to improve the health of its most vulnerable residents?*
3. *What is Washington State doing to shape Health Care Reform and how will it affect King County?*
4. *What is King County's role in transforming our health system?*
5. *Is this planning required? What are the opportunities and challenges of engaging in it?*
6. *What happens next?*

We look forward to your comments on the ideas we present in this paper; and would appreciate input by May 31, 2011. Please respond to either:

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1. What is King County's vision for the health of communities and individuals?

In 2010, the King County Council adopted the *King County Strategic Plan 2010-2014* which envisions “a diverse and dynamic community with a healthy economy and environment where all people and businesses have the opportunity to thrive.” One of its goals in support of this broad vision is providing opportunities for all communities and individuals to realize their full potential.

Achieving that goal involves working in multiple arenas, from fostering the underlying community conditions that promote health to ensuring that a network of integrated and effective health and human services is available to people in need.

2. How has our community worked to improve the health of its most vulnerable residents?

King County is home to an estimated 300,000 low-income residents (under 200% of the federal poverty level) who are uninsured or underinsured, including those on Medicaid or state-funded health programs. Many face complex health problems that may include co-morbid chronic medical conditions, mental health conditions, and substance use conditions. Some of these individuals and families are further characterized by frequent emergency department use, unstable housing or homelessness, and justice system involvement. These vulnerable residents face some of the greatest disparities in health outcomes, and they are associated with high costs in the health system.

The effective integration of service delivery systems for low-income, underserved people has long been of concern in our region. A wide range of regional partnerships involving public and private stakeholders in the community health, hospital, behavioral health (mental health/substance abuse), public health, housing, homelessness, early childhood, employment, developmental disabilities, veteran’s services, social service, academic, and criminal justice fields have helped our community to better coordinate, integrate, and evaluate activities. Structural changes in King County government have also helped foster better coordination, and in 1998, King County merged its mental health and substance abuse divisions. These collaborations both improved the health and well-being for county residents, and subsequently have helped us control growth in the costly criminal justice and emergency medical systems, as well as in other institutional settings.

In recent years, stakeholders across King County have been involved in several initiatives designed to foster integration in the health system.

- Extensive work on a **vision of integrated care** for the safety net population occurred in 2006, through the United Way of King County-sponsored Cross System Utilizer Work

Group¹. It envisioned that “the medical, mental health and substance abuse treatment agencies and practitioners that serve the King County safety net population will have clinical and structural mechanisms in place at the *system, agency and person levels* to achieve collaborative care and improved outcomes for the people they serve.”² The group called for a team approach to care, a strong focus on care coordination functions, use of a single care plan, medication coordination, patient-centered health homes, ability to exchange information electronically, and coordination of access to a continuum of services that included not just health but also housing, benefits, food, legal, and other supports. (If these principles sound familiar, they should – they are well-embedded in the delivery system envisioned under health care reform and the “triple aim” of better health, better experience of care, and reduced costs.)

- **Improved delivery systems for the safety net** were significantly advanced in King County through the Veterans and Human Services Levy (2006) and the Mental Illness Drug Dependency Action Plan (2007). For example, the Levy invested in the start-up of the Mental Health Integration Program, serving as a match to Washington State’s pilot effort to integrate mental health into primary care in the GAU (now Disability Lifeline) program.
- The **King County Ten Year Plan to End Homelessness**, launched in 2006, set ambitious goals for affordable housing production and more coordinated approaches to preventing and responding to homelessness—approaches that brought new partnerships in the health, housing, employment, and basic needs systems. Public and private funders closely coordinate investments in support of the plan’s goals, and cost offsets in the health system have been documented as a result of this work.
- In carrying out its **2007 Operational Master Plan**, Public Health-Seattle & King County and its partners have been taking steps “to increase the number of healthy years lived by people in King County and eliminate health disparities through access to affordable, appropriate, and quality health care services.” This work has included sponsoring forums on health reform and primary care/behavioral health integration. Public Health has also provided leadership in community planning for a safety-net health information

¹ Included representatives from Washington DSHS-HRSA, Harborview Medical Center, Valley Cities Counseling & Consultation, Public Health-Seattle & King County-Community Health Services; Health Care for the Homeless Network; and Jail Health Services, King County MHCADS, DESC, Community Health Plan, Neighborcare Health (then Puget Sound Neighborhood Health Centers), Harborview’s Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP), King County Jail Health Services, HealthPoint (then Community Health Centers of King County) and United Way of King County.

² Cross System Work Group Report to the Health and Chemical Dependency Impact Council, United Way of King County, Approved May 11, 2007

exchange under the Partnership for Health Improvement Through Shared Information – a key tool to support integrated delivery systems.

Through these and other initiatives, we have made important progress in bringing evidence-based programming to our care system (see the Appendix for more examples). Community-based non-profits in King County have secured federal and other grants to expand access to care and increase integration, and Washington State has funded pilots and demonstrations to improve coordination of care and control costs in Medicaid, Disability Lifeline, and other health programs. Pilots such as King County Care Partners and the incorporation of behavioral health services into the Disability Lifeline program are showing promising results. We are also fortunate to have in our community the expertise and involvement of academic-led entities such as the AIMS Center of the UW Department of Psychiatry and Behavioral Sciences and Harborview Medical Center's Center for Healthcare Improve for Addictions, Mental Illness, and Medically Vulnerable Populations (CHAMMP).

Through the learnings of these efforts, partners across King County have laid the foundation for continued progress in the three aims that have become a cornerstone of the Affordable Care Act and of Governor Gregoire's vision for the future health system: better health, better quality of care, and reduced costs.

3. What is Washington State Doing to Shape Health Care Reform and how will it affect King County?

Since the passage of the Patient Protection and Affordable Care Act (ACA), Washington State has been taking steps to prepare for full implementation of health care reform in 2014. Governor Christine Gregoire recently released "Health Care Reform the Washington Way," outlining a set of reforms designed to reduce healthcare spending while maintaining or improving the quality of care. These reforms include value-based benefits and payment reform, delivery system reforms, consumer engagement, and administrative simplification. Within the area of delivery system reforms, there is mention of integrated medical and behavioral health services, and the use of health homes for targeted populations with chronic medical illness and/or serious mental illness.

Last fall, in response to an [executive order](#) issued by Governor Gregoire on April 1, 2010, the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) transmitted a set of recommendations to the Governor regarding a future vision of health care delivery in Washington State. One of the recommendations under delivery system reforms was to "eliminate the current mental health Regional Support Network (RSN) and county-

administered chemical dependency treatment systems and move toward the delivery of fully integrated medical and behavioral health services through organized care systems.”³

Governor Gregoire's executive order directed the Health Care Cabinet to work collaboratively with other government jurisdictions, including local governments. Unfortunately, King County did not have an opportunity to be involved in the recommendations from HCA and DSHS regarding eliminating RSNs and county-administered chemical dependency systems, and, while we are open to structural changes, we have concerns regarding how such a change might affect the stability of individual clients, of behavioral health providers, and of our existing cross-system partnerships and best practice programs – all built over many years of careful planning.

King County recommends that Washington State not take immediate, solitary action to dismantle the Regional Support Network and the county's role in administration of substance abuse programs. We are concerned that such an action could inadvertently destabilize programs that are working well for high-need individuals or jeopardize over \$65 million per year in leveraged funding from the one-tenth of one-percent sales tax for the Mental Illness and Drug Dependency Plan, the Veterans and Human Services Levy, and other substantial state and federal grants received by DCHS.

Most recently, the State has submitted to the Centers for Medicare and Medicaid Services a proposal for a *Global Medicaid Modernization Initiative* that would involve significant changes to the design and financing of our health system for low-income people. Given the complexity and speed of the changes ahead – along with the King County's commitment to transparency and involvement of constituents who will be affected by these changes – time is needed to work closely with our community partners, with other counties and RSNs, and with our state government partners to develop a system of care that meets the needs of state health care reform efforts while also meeting the unique needs of King County.

4. What is King County's role in transforming our health system?

One of King County's goals is to advance the health and human potential of all its residents. Under the leadership of King County Executive Dow Constantine, two County agencies—the King County Department of Community and Human Services (DCHS) and Public Health-Seattle & King County (PHSKC)—oversee a wide range of policies and resources that influence health. They have a long history of working together, along with community partners, to advance health services integration through policies, system change, pilots, funding, training, information technology, and evaluation. DCHS administers the publicly-funded mental health and substance abuse treatment systems for low-income King County residents, and oversees additional service systems that link to and support health including housing, community

³ Transforming Health Care Delivery in Washington State, white paper issued by Washington State

development, homeless response, employment programs, developmental disabilities, and others. PHSKC works at a policy and community level to protect and promote health, assure access to care, and reduce health disparities. PHSKC works to assure that under health care reform, we will have systems that are accessible, patient-centered, integrated, cost-effective, focused on prevention, responsive to the needs of the community, and aimed at achieving health equity.

Working with state and federal funders and with our partners in the community, we hope to foster policy, system, and service delivery changes aimed at breaking down historic silos and reshaping our health system to become more accountable, more person-centered, more recovery-focused, and more prevention-focused. Our goal is to foster integrated systems that produce healthy individuals, families and communities, and we oversee extensive non-health resources (sometimes referred to as the “health care neighborhood”) that have a significant role in this.

Deliverable: Engage with the State and our local partners to develop a plan that moves us to models of integrated health service delivery which are based on a thorough understanding of the broader community strategies that will produce the best possible outcomes. We acknowledge that payment and service delivery reforms are needed to support and sustain such models, and we are anxious to collaborate in the design of integration model(s) that will benefit the residents of King County and help the Governor and State leaders achieve the vision of better health at reduced or controlled costs.

5. Is this planning required? What are the opportunities and challenges of engaging in it?

There is nothing under health care reform that specifically requires King County to engage in this type of planning. We are undertaking this initiative because we want our region to have a stronger voice in helping shape and influence the State’s design work, and because significant locally-controlled resources are involved. If we think through system design together, and with patients and clients, rather than in our separate sectors, we will end up with better results. We also know that if an integrated health system is designed in isolation and doesn’t work well for the at-risk populations we are concerned about, then county government will bear the consequences in increased criminal justice and emergency service costs. A number of our stakeholders are asking for the County to convene and lead this work, and to do so quickly, before the window of opportunity closes.

There are also challenges in convening this planning. There are potential conflicts of interest, different perceptions and perspectives that different parties bring to the table, and challenges in terms of understanding the implications of various health care reform proposals. One of the biggest challenges is the time demands that such a planning process presents to health care

and other system leaders, who are already busy with current daily responsibilities. We believe that the opportunities outweigh the challenges and risks.

6. What happens next?

Proposed Process:

We propose convening stakeholders for the purpose of designing and implementing strategies that help shift us from a system where health care is provided in largely siloed systems to a system where health care, behavioral health, and related support services are well-integrated and coordinated to achieve improved individual and population health outcomes.

We recognize that bringing people and organizations together to do this design work is a complex and thorny issue. To be successful, we must commit to being as transparent as possible. No single entity “owns” the issue and we bring different perspectives, expertise, and resources. Opportunities and threats are different – and evolving.

Who do we anticipate would be involved? King County (DCHS, Public Health); City of Seattle; other local governments; Washington State government; the mental health and substance abuse provider network; community health centers; Medicaid health plans; care coordination programs serving Medicaid and other vulnerable populations; hospitals; other local safety net providers; development disabilities; housing & homeless programs; long-term care; patients/clients, academic centers with expertise in integrated care; and both public and private funders.

Would this be an ad hoc planning group or ongoing? We think it is too early to answer this question. Much will depend on the results and usefulness of the initial scope of work in 2011, and how and whether other structures for safety net health planning evolve.

Work sessions. From June – December 2011, we propose sponsoring a series of work sessions (specific structure still to be designed) with stakeholders and partners. By the end of 2011, we anticipate having a written “design” product that communicates what an effective integrated service delivery model could look like for the safety net population in King County, and a roadmap or steps that would get us there by 2014.

While this work would include examining concepts arising in other parts of the state, such as a “regional healthcare authority” that the Southwest Washington region is considering, it is too early to endorse any specific model at this time. Further, although the proposed planning activities would be working to design an accountable, integrated system, this process is unlikely to end up in the design of a specific Accountable Care Organization (ACO). That said, this work could help our community shape future ACO(s) or similar structures that would be effective in addressing the needs of our most vulnerable residents.

Early feedback on our thinking

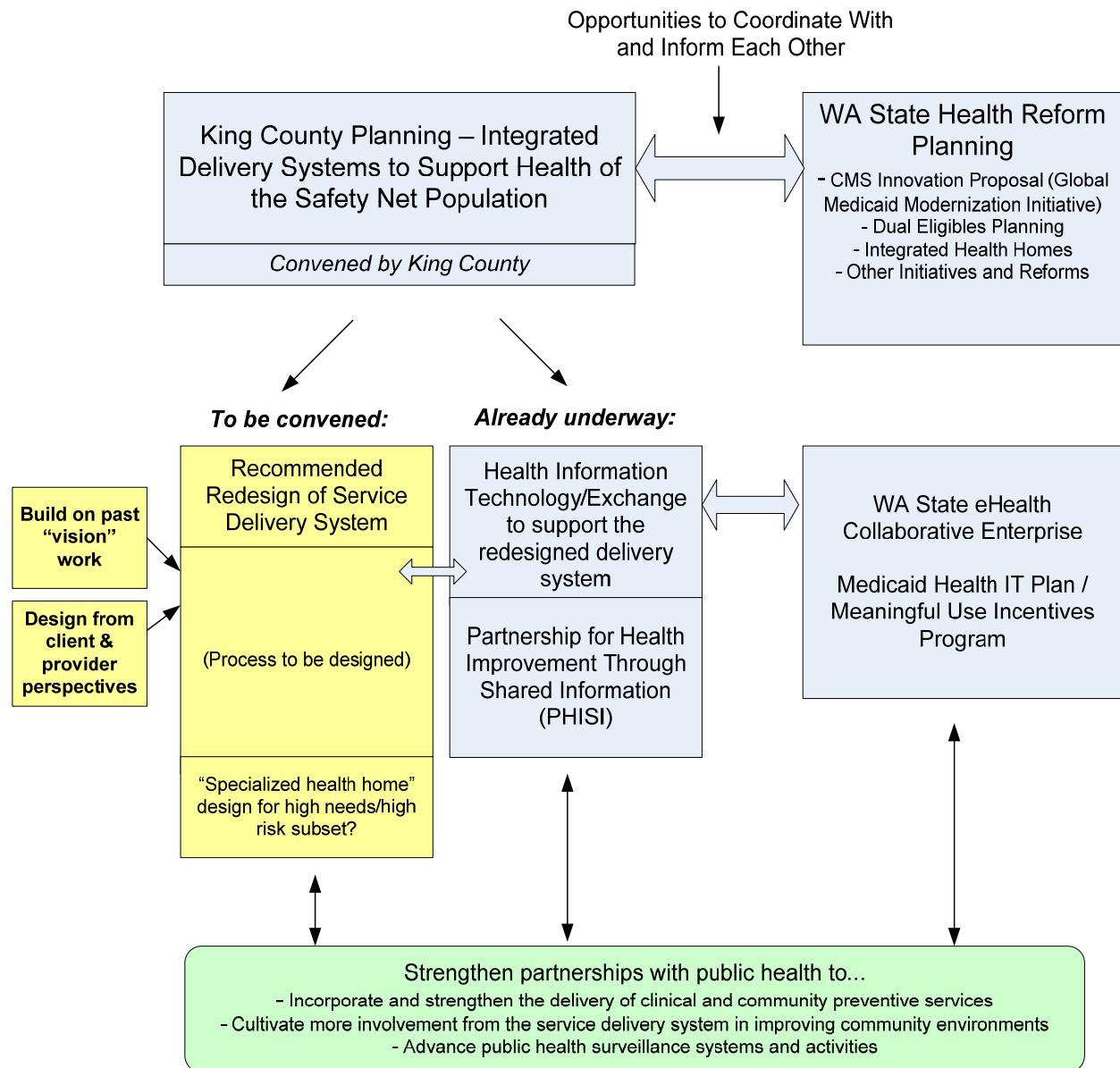
Last month, we had an opportunity to get some early feedback on this proposal at the Mental Health-Chemical Dependency-Primary Care Integration Committee meeting. Themes included:

- Any work on service delivery redesign should be approached from a patient/client and workflow perspective. We'll need to build a shared understanding of the basics of how our health and behavioral health systems currently "work" in King County – both for the insured and the uninsured – and the relationship they have with systems such as housing and shelter, day programs, employment, senior services, community health workers, criminal justice, and others. This will allow us to analyze our systems and programs, challenge ourselves to root out areas of potential duplication, waste, and gaps, and identify strategies and system designs that improve integration and drive better health outcomes. We heard that we should start with these types of activities and analyses, and then move to the payment and other structures needed to enable it. If we don't approach it from this angle, people and organizations won't participate openly and there may be power struggles.
- Involve safety net patients/clients and front-line staff. We need to learn from them to be successful, probably through some smaller tables. That work can then "bubble up" to a larger steering or advisory group table.
- We need to continually understand more about the State health care environment, both what is happening today and the vision/roadmap for fully implementing health care reform in 2014. For example, the State was recently selected to design a care model for dual eligibles (those on both Medicaid and Medicare), and is working with the CMS Innovation Center to design a "Global Medicaid Modernization Initiative." We need to learn more about the constraints and opportunities under which they are working, assuring that we can be an effective partner with the State to help implement models in ways that work well for our county's residents.

We welcome your comments. We anticipate moving ahead with a kick-off gathering in June 2011.

Comments and questions should be directed to either: Amnon Shoenfeld, King County Department of Community & Human Services amnon.shoenfeld@kingcounty.gov or Janna Wilson, Public Health-Seattle & King County janna.wilson@kingcounty.gov.

DRAFT Concept – Planning Structure and Relationships



Appendix: Progress in Integration – Examples of Existing Local Partnerships

Service systems in King County have made substantial progress in integrating care over the past decade. The table below summarizes a number of specific delivery system reforms that King County DCHS and PHSKC have been involved in. The complexity and richness of our programs, many of which are intertwined with State initiatives, is part of the reason we need to take time and care in designing our future models.

Delivery System Area	Progress
Convenor/planner role	<ul style="list-style-type: none">In 2008, PHSKC and DCHS jointly convened a primary care and behavioral health integration committee including representatives from Harborview, Jail Health Services, the University of Washington, Community Health Plan, Molina, DSHS, CHCs, and behavioral health agencies. This committee has met regularly for the past three years to exchange information and build collaborative relationships to foster integration of healthcare for the safety net population of King County.
Funding	<ul style="list-style-type: none">Through county-level resources such as the Mental Illness and Drug Dependency Plan (our one-tenth of one percent sales tax) and the King County Veterans and Human Services Levy, along with competitive federal grants that we have secured, King County is accountable for over \$65 million in leveraged funding linked to behavioral health integration.
Evidence-based integration of mental health and substance abuse services into community and public health centers	<ul style="list-style-type: none">King County worked collaboratively with Community Health Plan of Washington and the University of WA to successfully implement the General Assistance-Unemployable (GA-U) pilot program, which provides integrated behavioral and primary health care services to the GA-U (now Disability Lifeline) population in a program called the Mental Health Integration Program. An evaluation of the first 21 months of this pilot program has just been completed, and results are very encouraging in terms of its potential to reduce inpatient medical and psychiatric hospital admissions as well as arrests.

<p><i>Continued</i></p> <p>Evidence-based integration of mental health and substance abuse services into community and public health centers</p>	<ul style="list-style-type: none"> • Local funding from the King County Veterans and Human Services Levy was used to expand the pilot, allowing it to serve additional people in the safety net population. <i>Services are now integrated into 22 primary care clinics in King County and reach 8200 adults per year.</i> • Transparency of cost and quality information has been a feature of the Mental Health Integration Program. In 2010, 45% of clients served demonstrated a clinically significant decrease in depression or anxiety symptoms as measured by standardized symptom scales.
<p>Health Information Exchange planning – electronic information sharing to promote integrated care</p>	<ul style="list-style-type: none"> • King County, United Way of King County, the City of Seattle, and the University of WA joined together to launch the “Partnership for Health Information Through Shared Information (PHISI).” Numerous stakeholders across the health care safety net formed a Board that is now working to design and implement a health information exchange. DSHS Secretary Susan Dreyfus is a member of the PHISI board. • PHISI is coordinating with the Health Care Authority’s eHealth Collaborative Enterprise and exploring use of state HIE infrastructure and a partnership with PRISM. • An initial planned use of the HIE functionality is to allow sharing of medication information across health care organizations who may be working with the same patient. This should result in better care and reduced medication costs among the Medicaid population.

Quality improvement and integration initiatives in RSN agencies	<ul style="list-style-type: none"> • Since 2006, DCHS has engaged in a quality improvement project designed to reduce morbidity and mortality attributable to cardiovascular disease among clients with schizophrenia receiving public mental health services and taking atypical antipsychotic medications. • We have a new smoking cessation program in mental health and substance abuse treatment agencies: King County DCHS received a \$150,000 ARRA “Communities Putting Prevention to Work” grant from PHSKC for this purpose. • We integrated services for individuals who are served in both the developmental disabilities system and the alcohol and drug treatment system by developing and supporting the STAR (Substance Treatment And Recovery) program.
High-Need / High Cost / High Utilization Initiatives	<p>King County is a partner and funder in multiple initiatives focused on high-cost, high risk individuals with chronic health conditions. Many of the people served in these programs are Medicaid or DL enrollees, and a subset are dual eligible for Medicaid/Medicare.</p> <ul style="list-style-type: none"> • <i>Supportive Housing.</i> In the past three years, developed over 400 units for homeless adults with chronic medical and behavioral health conditions by partnering with United Way, City of Seattle, King County, housing authorities, and local non-profits. Evaluations of three of the housing programs found reductions in hospital emergency room and inpatient utilization of between 41% and 81%. • <i>Client Care Coordination</i> – a new method that DCHS and PHSKC have established, working with United Way and local housing agencies, whereby we proactively identify high utilizers of health services and prioritize them for supportive housing units. This is a strategy for reducing health care costs, reducing justice system costs, reducing homelessness, and improving health and well-being.

- *Housing Health Outreach Team* – an interdisciplinary medical-behavioral health team performing outreach & care management functions in low-income housing sites taking high-need adults with complex chronic health conditions.
 - *PACT, FACT, and FISH teams* – Evidence based interdisciplinary case management for people with serious mental illness.
 - *Mobile Medical in South King County* – We used local Levy funds to pilot an integrated medical-behavioral health team that takes a mobile medical van to 8+ homeless feeding programs in various south county communities, engaging with chronically homeless adults.
 - *Diversion and recuperation programs (strategies for preventing hospital admission and overstays)* – King County is expanding its programs to divert people in crisis from unnecessary trips to jails and hospitals. Recuperation programs will help reduce hospital overstay days and reduce hospital readmissions. Linkages to housing help promote long-term stability.
 - *King County RSN Study of High Utilization of Medical Services by RSN Enrollees*. KCRSN, in partnership with King County mental health center medical directors, conducted a study to understand the factors that lead to high utilization of medical services by mental health clients. State data were used to identify 200 King County residents with schizophrenia who were the most costly to taxpayers in terms of hospitalizations, psychiatric medications, and emergency room use in 2006.
- The programs above coordinate with State Medicaid programs and with care management initiatives such as King County Care Partners.